Challenges in Implementing Disaster Mental Health Programs: State Program Directors' Perspectives

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The Crisis Counseling Assistance and Training Program grants supplemental federal funding to states and territories for individual and community crisis intervention services in the aftermath of presidentially declared disasters. Little research has been conducted to evaluate the effectiveness of these services, and few data exist to guide policies and programs. A qualitative study of thirty-eight state program directors (representing 95 percent of all such programs over a five-year period) identified the numerous challenges that states experience when planning, applying for, implementing, maintaining, phasing out, and evaluating these federally funded programs. The results highlighted the importance of including mental health in state-level disaster plans, fostering collaborative relationships across institutions, clarifying program guidelines, sharing innovations across programs, and building state capacity for needs assessment and program evaluation.

Keywords: crisis counseling; disaster mental health; community outreach; indigenous workers; state capacity; disaster preparedness

Federal disaster areas are eligible for a wide range of services, including the Crisis Counseling Assistance and Training Program (CCP), available since 1974 under the Robert T. Stafford Disaster Relief and Emergency Assistance Act (Public Law 100-707). Funded by the Federal Emergency Management Agency (FEMA) and administered by the Substance Abuse and Mental Health Services Administration's (SAMHSA's) Center for Mental Health Services (CMHS), the CCP aims to meet the short-term mental health needs of disaster-stricken communities through a combination of outreach, education, brief counseling services, and referral. Outreach and public education

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serve primarily to normalize reactions and to engage people who might need further care. These roles are often, though not exclusively, performed by paraprofessionals who work throughout the community, including schools, places of worship, and places of work. Crisis counseling helps survivors to cope with current stress and symptoms to facilitate their return to predisaster levels of functioning. Crisis counseling, which is differentiated from treatment in the program model, relies largely on active listening. Counselors are expected to refer clients to other services if the person has or has developed more serious psychiatric problems.

Receipt of funds for crisis counseling is not automatic. Eligible states may apply for the Immediate Services Program (which operates for the first three months postdisaster) and the Regular Services Program (which operates for the next nine months). In these applications, which must be submitted two weeks and two months postdisaster, respectively, states must establish that the need for mental health services is greater than state and local governments can be expected to meet, and they must present a detailed plan about how the grant will enable them to meet these needs. State mental health systems (or their equivalents) serve as host systems upon which funded CCPs are superimposed. These systems are often composed of a variety of local government units, social service agencies, and community-based organizations and are thus inherently complex and challenging to manage. Host systems have preexisting missions and vary in capacity, preparedness, and evalua-

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qualitative methodology. With more than twenty-two years' experience as an operational and administrative manager in a corporate environment, she currently provides human technologies training in a variety of settings.

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tion expertise, and they are both assisted and constrained by the federal system of emergency management, most specifically, the guidelines of the CCP (Norris et al. 2006, 2005).

Previously published accounts of disaster mental health services and programs have alluded to numerous problems that interfere with the timely or effective delivery of services (Myers and Wee 2005; National Institute of Mental Health 2002). Unsolicited groups of well-meaning volunteers have become one of the major sources of chaos in disaster-stricken settings (Bowenkamp 2000; Gist and Lubin 1999; Hodgkinson and Stewart 1998; Lanou 1993; Sitterle and Gurwich 1998). Less experienced providers may suffer from vicarious trauma, leading to distress, absenteeism, and erosion of staff morale (Call and Pfefferbaum 1999). Staff may self-segregate into those more and less directly affected personally by the disaster (Sitterle and Gurwich 1998). Turf boundaries, communication gaps, confusion, the emotionally stressful nature of disaster work, ambivalence and suspicions regarding outsiders, funding gaps, limited resources, lack of long-term care, and survivor stigma are other problems that may interfere with service delivery (Bowencamp 2000; Canterbury and Yule 1999; Hodgkinson and Stewart 1998; Lanou 1993; Norris et al. 2006, 2005).

Building upon these past writings, the purpose of the present study was to increase understanding of the challenges involved in providing disaster mental health services by capturing the experiences and perspectives of a representative sample of state program directors. CCP directors are the intermediary between a variety of voices speaking for the local community, the state, and the federal government, making their perspectives especially important for understanding the process of implementing a disaster mental health response. In accord with previous writings, we explored issues of preparedness, communication, collaboration, and capacity in considerable depth. The study was based on the assumption that the quality of mental health services provided to disaster victims is based not only on their clinical efficacy but also on the capacity of systems to deliver those services in a timely and effective way.

Method

Sampling procedures: Disasters and directors

To qualify for this study, states must have received Immediate Service Program or Regular Service Program grants between 1996 and 2001, and they must have closed out the grant no later than December 2003. This rule excluded Project Liberty, New York State's response to the terrorist attacks of September 11, 2001, which did not close out until September 2005. States receiving SAMHSA Emergency Response Grants (SERG) over the same time frame were also included. Directors of responses to thirty-seven (of thirty-nine eligible) disasters in twenty-five (of twenty-seven eligible) states participated. A total of thirty-six interviews of thirty-eight people were included in this analysis (one interview was lost due to

equipment failure). Most of the responding state agencies existed under the guidance of state divisions or departments of health, mental health, or mental health and substance abuse.

Table 1 shows the states and disasters represented by the research. The types of disasters experienced during this time frame ranged from widespread to contained, natural to human caused, no injuries/deaths to multiple injuries/deaths, single component to multiple components (e.g., hurricane *and* flood), single event to one in a series of events, and short-term to long-term response engagements. The communities involved in these disasters varied in size, location, ethnicity and population distribution, and vulnerability to multiple events.

We interviewed state program directors between May and August 2004, usually in person, by using a semistructured interview protocol consisting of open-ended questions. This protocol was revised from one that had been used in previous case studies of responses to the Oklahoma City bombing (Norris et al. 2005) and the World Trade Center disaster (Norris et al. 2006). Although the job titles of respondents varied across states, the majority of individuals reported their primary function as "administrator." Other descriptors used were coordinator, planner, manager, facilitator, leader, and technical assistance provider. Each brought a different role expectation, background, and sense of mission to the position. Most respondents held an advanced degree related to the mental health field.

Data analysis

All interviews were audiotaped. Transcribed materials (interviews, field notes, and memos) were converted to text files and imported into QSR N6 software for qualitative data analyses. A framework for coding the material was developed based on the concepts of the interview as well as the themes that emerged from previous case studies in Oklahoma City and New York. A code tree was devised containing both the code scheme and operational definitions for each code. Members of the research team met several times during the development of the code tree to ensure its validity and reliability across multiple coders. During these meetings, team members would be asked to code the same short sample passage. Once coded, team members would discuss what code(s) they assigned to the passage and why. These coding strategies were debated until consensus was reached regarding what code should be applied and how it should be operationally defined. Half-day training sessions were then conducted with all coders. Coders consisted of two of the authors, who had also been field researchers for this study, plus two Ph.D.-level qualitative researchers, two Ph.D. candidates with qualitative coding experience, and a master's-level practitioner who had been involved with a previous case study.

Results

Results were organized into a temporal framework proceeding through preparing for the disaster, implementing the response, providing services to the commu-

TABLE 1
STATES AND DISASTER DECLARATIONS INCLUDED IN THE DIRECTORS' STUDY

State	Event Date	Event Type	Disaster Number[a]	Year of Closeout
Alaska	06-07-96	Fire	1119	2000
Alabama	04-09-98	Tornado	1214	2000
	09-30-98	Hurricane	1250	2001
	12-18-00	Tornado	1352	2002
Arkansas	03-02-97	Tornado	1162	2001
	01-23-99	Tornado and flooding	1266	2001
Colorado	08-01-97	Flooding	1186	2002
District of Columbia	FY 2003	D.C. sniper	SM00164	2003
Florida	01-06-98	Tornado and flooding	1195	2000
	06-18-98	Wildfires	1223	2000
	09-28-98	Hurricane	1249	2001
Idaho	01-04-97	Flooding	1154	2001
Iowa	07-22-99	Flooding	1282	2001
Kentucky	03-04-97	Flooding	1163	2001
Maryland	FY 2003	D.C. sniper	SM00171	2003
Minnesota	04-08-97	Flooding	1175	2001
	04-01-98	Tornado	1212	2000
Missouri	05-12-00	Flooding	1328	2003
Montana	08-30-00	Wildfires	1340	2003
North Carolina	09-16-99	Hurricanes	1292	2002
North Dakota	04-07-97	Flooding	1174	2001
	06-08-99	Tornado	1279	2002
New Jersey	09-18-99	Hurricane	1295	2001
New Mexico	05-13-00	Wildfire	1329	2003
Ohio	03-04-97	Flooding	1164	2001
Rhode Island	02-20-03	Nightclub fire	SM00175	2003
South Dakota	04-07-97	Flooding	1173	2001
	06-01-98	Tornado	1218	2001
Tennessee	01-19-99	Tornado	1262	2001
Texas	08-26-98	Flooding	1239	2001
	10-21-98	Flooding	1257	2001
	04-07-00	Tornado	1323	2003
	06-09-01	Tropical storm	1379	2003
Virginia	09-18-99	Hurricane	1293	2002
	FY 2003	D.C. sniper	SM00163	2003
Wisconsin	05-11-01	Flooding	1369	2003
West Virginia	06-03-01	Flooding	1378	2003

a. These are Federal Emergency Management Agency (FEMA) numbers unless preceded by *SM*, which is used to designate Substance Abuse and Mental Health Services Administration (SAMHSA) emergency grants that are occasionally given to states in the absence of a presidential disaster declaration.

nity within the framework of the CCP model, integrating the CCP into community and state systems, phasing out the response, and evaluating the response.

Preparing for the disaster

Directors' comments about predisaster planning and preparation clustered around three main topics: the presence or absence of a plan, preparatory activities, and predisaster training. Few states had a disaster plan in place prior to the index disaster. Descriptions of plans ranged from nonexistent to fully developed, with those states reporting more frequent or higher-profile disasters also reporting more fully developed disaster mental health plans. Developing a disaster plan was a low priority in states that rarely experienced a disaster. Even so, plans were often described as vague or as still under development. The all-hazards or disaster plans of most states did not include (or only minimally referenced) plans for responding to mental health needs. Programmatic, political, and personal variables were often cited as reasons for poorly developed or nonexistent plans. Respondents who reported experience with a previous event, either as a provider or as a state official, were more likely to report that they felt personally prepared to respond. Feeling prepared to respond to the index disaster was not related to the number of disasters experienced by the state during the five-year sampling frame, the amount of federal dollars received for the disaster, or the type of disaster experienced.

Three elements of preparedness were commonly perceived as necessary for an effective and efficient response. The first element was designation of provisions, ranging from supplies (such as necessary forms, identification badges, writing utensils, updated phone lists) to more substantial resources (such as a designated space to set up a command post, dedicated phone lines, and online technology). The second key element was the need to establish relationships with other agencies (such as the Red Cross and local agencies in the event area). States with the most fully developed plans stressed the need to formalize relationships with memoranda of understanding and the development of councils with representatives of these agencies that met periodically in the absence of an event to discuss roles, response options, and regulatory issues. The third element was plans for having all key decision makers at the strategic command post (federal, state, and local government agencies plus other agencies, such as the Red Cross) to ensure that critical decisions were made in a timely manner.

Training was highlighted as another crucial component of disaster preparation. The FEMA training at Emmitsburg, Maryland, was perceived as vital for helping state directors feel and act prepared once an event occurred. Particularly helpful components of the training included learning from others who had experienced a disaster and assistance with grant writing. FEMA online courses were also cited as useful and convenient. Participants expressed concern about the reduction in the number of times the training is now offered. In addition to federal trainings, trainings were offered by the states. These trainings attempted to build capacity either through train-the-trainer events or through more general trainings to local community agencies. Some respondents reported that they hosted forums and trainings throughout the year during which responding agencies (e.g., Red Cross) would attend and participate in role-plays, tabletop exercises, and disaster response planning sessions. Trainings in Critical Incident Stress Debriefing and

Management (CISD/CISM) techniques were used by many states. Despite research questioning the effectiveness of CISD/CISM, some states believed CISD and CISM trainings are as important to preparing for a disaster as is the FEMA Emmitsburg training.

Implementing the response

The initial phase of a disaster response was described as chaotic due to the many competing needs and priorities of the first week. State leaders found it difficult to attend to the needs and safety of the community while handling the administrative demands that accompany applying for federal funding to support a disaster mental health response. For these reasons, this part of the process was often referred to as "the second disaster," or the "bureaucracy that, although they're trying to help, comes in." One director reported,

> In the first 48 hours, you're not really worrying about how the crisis counseling program should be run. [Y]ou're still in the response mode of responding to that major disaster in the first 48 hours. What you do find yourself worrying about is . . . you got this 14 day deadline . . . and you worry about . . . getting the information . . . to the right people . . . your local providers, while they are responding.

Additionally, state leaders found the needs assessment problematic as data were described as "anecdotal," "unreliable," and "insufficient."

Several key sources of support were seen as being helpful to the initial response phase. Most state leaders who had attended the FEMA training at Emmitsburg felt somewhat prepared to write the grant application. The CMHS project officer was often cited as another important source of support. Functioning as part of a multidisciplinary team helped states gather information and implement the disaster response. Accessing multiple sources, such as news media (radio, television, Internet, and print), speaking with Chamber of Commerce and public safety representatives, and reading situation reports from workers in the field were cited as useful strategies for obtaining information. Finally, contacting people who had previously been involved in disaster response was always recounted as positive and helpful in educating the state representative and moving the response effort forward.

Providing services within the CCP model

After the first week, interviewees indicated that their attentions were drawn to designing a longer-term response. This process included gaining an understanding of the CCP model that emphasizes outreach, crisis counseling, and referral. Training was an essential aspect of understanding and delivering services within this framework.

Outreach. Outreach was a key component of every CCP and was generally thought to be effective by directors. Outreach is intended as a form of public education where the outreach workers, preferably indigenous, literally go out into the community to educate victims of the disaster regarding what responses they may experience as a victim of the disaster, what types of services are available to them, and where services may be obtained. Directors noted the importance of carefully identifying target populations and employing workers indigenous to those populations.

Unsolicited groups of well-meaning volunteers have become one of the major sources of chaos in disaster-stricken settings.

All states identified target populations, although they varied across communities and across events. Each program recognized the differences in its community population and took great efforts to meet the needs of everyone. Special populations specifically mentioned as adversely affected were older adults, American Indian or Hispanic residents, and children. Other populations mentioned were migrant workers, undocumented aliens, the developmentally disabled, Vietnam veterans, farmers, the homeless, the mentally ill, African Americans, and numerous immigrant populations. Although methods of conducting outreach were fairly standard across programs, strategies were highly dependent on the target population. And although many types of outreach workers were employed across the disasters, indigenous workers were often observed as having the most success in reaching the community's hardest-hit areas. In this context, "indigenous" did not necessarily refer to membership in a minority population, but rather to individuals embedded in the community. One director commented,

> Outreach in a Hispanic neighborhood will work, particularly if you have indigenous people. Door-to-door outreach in the Muslim neighborhood will not work. It's just, it just doesn't work, so you have to come up with other plans . . . your response kind of has to be keyed to . . . who you're dealing with and it's a different approach for different types of communities.

There were several challenges noted regarding outreach. Staff turnover was frequent, most often due to acquiring better jobs, being victims themselves, or suffering burnout. There were some concerns about the use of paraprofessionals for out-

reach, especially in the area of having "untrained" or unlicensed workers in mental health roles. Another challenge for many state directors was locating victims without the use of the FEMA Registration List. This list contains the names and contact points for individuals who apply for FEMA services. Until the late 1990s, this list was made available to CCP programs as a resource to help program providers locate victims. However, a federal policy change in the late 1990s restricted the availability of the list due to concerns around consumer confidentiality.

Illiteracy and multiple languages in a minority population created potential for gaps in the outreach programs. Sometimes, even indigenous workers did not realize all of the challenges in reaching a diverse population. One interviewee reported,

> So they developed a pamphlet to help deal with some of the stresses and all. . . . And then, after they developed it, they realized upon trying to distribute it, that there were very few of the whole population that could read their own language.

Providing outreach to large groups was challenging as not everyone in a group had the same level of exposure, making it difficult to find a single message acceptable to everyone. Many directors spoke of the discomfort among disaster victims in a group when it became obvious that some had experienced minimal losses while others had endured losses of family members, homes, health, and material possessions.

Some areas and populations simply did not welcome outreach workers and their attempts to help. Sometimes, the resistance was passive and polite; community members simply refused services or said they would consider services later. But occasionally, the resistance was aggressive and hostile. One director described the challenge this way:

> The [outreach workers] were feeling very intimidated . . . by people they were contacting in the areas who had been evacuated . . . I would say more in the working class areas, where, where people just didn't like to be bothered. . . . They weren't received very well, . . . actually, hostile aggressive dogs and people. They were feeling like they didn't have the skills they needed to deal with being met with aggression.

Counseling. Crisis counseling was difficult for directors to define. Although most agreed that crisis counseling is not intended to be therapy, the boundaries of crisis counseling remained blurred across programs and across states. Definitions ranged from "active listening" to "a wellness model" to therapeutic interventions. Because of this, the use of paraprofessionals as counselors (as opposed to outreach workers) was vigorously debated, although most directors thought they could be trained to be effective with supervision. As a result, it is difficult to know exactly what services were being rendered under the auspices of the crisis counseling. One director observed,

> A therapist or traditional mental health person sees the mud covered survivor and . . . is gonna say, "Gee, how does that mud feel?" and the disaster mental health person sees that [same person] and says, "Let's get that mud off of you."

Referrals. Referrals posed a number of challenges. First was the issue of when to refer. Estimates of referrals for each program ranged from "minimal—not enough to count" to "4-7% of all contacts." Most programs observed a formula for when to make a referral. When a person accessed the system a certain number of times and desired more access, they were referred to a professional service. However, there was disagreement regarding the number of visits that would trigger a referral, with the numbers ranging from three times over the course of the program to ten times in a single month. Another strategy for making a referral was the identification of "red flags," such as persons expressing suicidal/homicidal thoughts, new or increased substance abuse, and exacerbation of preexisting mental illness. A final issue focused on system capacity. Most clinical directors expressed sensitivity to the already burdened mental health systems into which contacts were referred; nonclinical directors did not recognize system capacity as a problem. One respondent summarized the dilemma of referrals this way:

> Referral is probably the weakest part of this program because of two reasons. . . . One, you are dealing with paraprofessionals so their ability to . . . actually determine . . . who should be referred. . . . The other problem is you're trying to refer into a system that's already overloaded. . . . It's very hard for my [community mental health system] to get people into their system when there's already a 6-month waiting list for services.

Training. Training was undertaken to ensure compliance with federal program requirements and to enact a quality response. Directors' comments fell into three general categories: (1) the types of training offered, (2) the timing of the training, and (3) the trainers/instructors available to do the training.

There were both federal and state trainings. In many cases, the boundary between federal and state training became blurred, especially in states that experienced multiple disasters, as the state often took the initial training received from the federal agency and offered it down to the provider level. FEMA and CMHS trainings centered on explaining the basics of the Crisis Counseling Program, grant administration, and grant adherence. Issues of concern around the training included the organization of the course content and the level of detail presented. One director commented, "CMHS has a lot of material but they don't have it organized in a way . . . that they can present to states, where it goes from A to Z. Lots of little pamphlets or this is how you do this, but not necessarily something that says this is what you do starting with the event."

Another highlighted the need for clear and succinct training material by saying,

> What I need is a short, sweet, clear . . . bulleted procedure that explains it instead of 85 pages of, "This is something that's expected." What I need is the ability to translate this program clearly, articulately, and quickly so that people can make decisions based on, "Now I understand what you're asking me to do." It needs to be clearer.

One of the biggest challenges in providing training to a large number of people in the smallest amount of time is how to match the course content to the audience. One director recollected,

> The first official kick-off [training] was done by an outside provider that CMHS recommended, and he was here for 2 days. I was not very happy with it for a lot of reasons. The first day, everybody in the community was invited to it, which I thought was sort of crazy, but . . . that's what we were told to do. It turned into a debriefing for 300 people. It was just a waste of time.

The timing of the training was often cited as a critical factor contributing to whether the training was considered successful. If offered too soon, staff turnover left new untrained staff in their place, some workers were too focused on responding to the disaster, and many of the attendees were still coping with their own reactions. This was especially important in smaller programs where staff unavailability was often cited as a barrier to successful training. If offered too late, many programs reported that their crisis counselor and outreach workers were already out in the affected areas without clear guidelines; thus, "some of the disaster survivors started immediately to create a dependency on the program."

Training instructors came from a variety of resources and backgrounds; there was no apparent consistency, however, across events and/or across states regarding whom to call for what training. Most of the respondents acknowledged that their CMHS project officer made them aware of a resource list of "experts" who were approved to conduct certain types of training. Instructors and the trainings they conducted from this list were usually acknowledged as very effective. Others invited trainers with whom they had personal experience or individuals with good reputations in the field.

A noted strength of the program was being able to develop a team approach to training. Trainings developed in any part of the state could be taken to other parts of the state because federal dollars were supporting the training efforts. This effectively facilitated the dissemination of critical information and eliminated the boundaries that might otherwise have been activated had local dollars been used for training.

Integrating the CCP into community and state systems

The CCP model focuses on providing a community-level response. Program directors are confronted with quickly integrating a program into preexisting host communities and systems of services. The primary challenges in this task are establishing effective and accurate communication; developing collaborative relationships with local agencies as well as other responding agencies; accessing existing institutions, such as the schools and faith-based organizations; resolving turf issues; and developing an effective system for acquiring and transferring funds from the federal authority, to the state coffer, into the CCP, and out to the direct service providers and agencies.

Communication. Receiving and relaying timely and accurate information is critical to the establishment of the program as a credible and reliable source of information. Additionally, it contributes to relationship building, both between and

within agencies and systems. Both formal and informal methods were used to accomplish this. Methods included the establishment of communication during the year with various agencies through one-on-one conversations, group meetings, teleconferences, and the development of performance contracts with each agency that were reviewed and renewed annually. Although communication during the events was reportedly effective and uneventful, a few directors experienced delays in communication from the federal level (i.e., top-down communication) and conflict in communication at the local level (bottom-up communication). It was not uncommon for a director to report, "The Feds weren't giving us clear messages. Things were always changing, so it looked like we didn't know what we were doing."

The all-hazards or disaster plans of most states did not include (or only minimally referenced) plans for responding to mental health needs.

Collaboration. Most of the directors recognized that the sheer size and scope of disasters demand collaboration between responding and supporting agencies, although most also stated that developing collaboration is neither simple nor without its challenges. As such, developing collaborative relationships is part of planning before, during, and after disasters so that "you won't be out on a limb by yourself."

A few directors indicated that initiating collaborative relationships during the disaster was too late, too time-consuming, and generally nonproductive due to the pressure of each agency trying to respond to the disaster with its own protocol and/or mission. Most state leaders, however, reported many creative and productive ways of forming relationships that optimized the reach and success of their CCP program. For instance, employing indigenous workers to staff the CCP created instant links to the local community and access to its institutions. Pairing outreach workers with other service delivery agencies and their staff (e.g., Meals-on-Wheels, law enforcement) contributed to the formation of good working relationships between the CCP and other responding programs, plus it increased the outreach impact and the credibility of the CCP by associating the outreach worker with a person already trusted with an ongoing service. One of the best opportunities for forming new relationships was participation on unmet needs committees that brought community and program leaders together in an effort to identify the needs of the community and devise a plan to meet those needs.

Many leaders reflected that a legacy of their program was recognition of the need to have a mental health person "at the table" in disaster preparedness activities. Another legacy was the acknowledgement of the value of developing collaborative relationships before the next event; therefore, leaders found themselves involved in collaborative activities to form new relationships while strengthening old ones.

Developing collaborative partnerships was not without its challenges. Some agencies were resistant. For instance, one community resisted help from the CCP because they wanted to "do it themselves." The director commented,

> It was an agency issue. It was the agency thinking, "We want to do this ourselves," and I kept telling them that you're gonna have to hire somebody. And they kept saying, "No. They're our responsibility. This is our community and . . . we're going to do this," but it didn't work.

Some leaders felt they did not have the skills they needed to develop collaborative relationships with other agencies. One director commented, "If someone could develop a course in how to get people to play well in the sandbox, *that* would have been good training." Some directors remarked that it took time to be recognized as a "player." Several leaders cited how easy it is to ignore the collaborative relationships in the absence of an event. One leader summed up the postdisaster challenges by saying, "Everybody gets busy, and we don't touch base as often as we should, and we're in different buildings. It's difficult."

Access and turf issues. Schools and faith-based organizations served as two primary institutions for gaining access to affected populations. Gaining access to schools was generally difficult, with one director characterizing schools as "an insular societal group." One director summed up the inconsistencies of being able to gain access to the school system this way:

> [Access to schools] varied by area program. In some cases, they had a wonderful relationship with schools, and they would go in and provide information to teachers and in some cases classrooms and in other areas, they could not get a foot in the door, and they weren't considered . . . qualified . . . or the feeling was to address this with the children would increase their anxiety . . .

Barriers included resistance to the idea of having the CCP in the school system and difficulty finding a time to present the program with minimal disruption to the students' schedules. In many cases, the disaster occurred when school was not in session, creating even more challenges to accessing groups of children for outreach. For those programs that were able to access the school system, creativity, persistence, and patience were the keys. These programs used teachers as outreach workers, connected directly with teachers by offering key training, included members of the school system in key multiagency teams, and simply stood by until schools contacted them due to mounting problems with students. One director recounted,

> Just as we closed a program down, the principal, who had been saying for weeks . . . that "everything'll be all right as long as we get back on schedule," broke down and said, "Help me." So we went into those schools when the program was over.

Most respondents agreed that faith-based organizations were easier to access than school systems. As collaborative partners, faith-based organizations were key sources for outreach and referral. Although the directors cited many positive aspects regarding the accessibility and participation of the faith-based organizations, directors also reported: difficulties when congregations subscribed to a "just world" paradigm; concern as to how to make referrals to faith-based resources; and some organizations' disinterest in partnering with the CCP.

It is always difficult to have multiple people, agencies, and institutions involved in a systems response and not have insider/outsider or turf issues arise. Turf issues arose between and across state and federal agencies, the military, the Red Cross, local agencies, and providers. Most turf issues revolved around questions of who was in charge and who had ownership of a particular role. One director gave a classic example of turf issues among multiple government and responding agencies by saying,

> Because it was a national [site], the Department of [anonymous] assumed they were under control, that they were the incident commander. The fire folks thought they were the incident commander and controlled the incident. Local emergency management in [city] thought they were, and the state's office of emergency management thought they were in charge. The [special population] thought they were in charge of what was going on on their land, and then they found out they really weren't, and then the sheriff in [county], he thought he had control over all of that. Nobody was in charge.

In some cases, turf issues appeared to stem from a common belief that only "locals" could understand their states. The feelings of several directors were captured with this comment:

> We're the ones living the disaster. We're the ones on the front lines responding, and we could do a better job of organizing the [response]. They ought to step aside and let somebody else lead the thing.

Although the majority of such comments related to working with the Red Cross, leaders also reported insider/outsider issues between their state and other local responding agencies. Turf issues at the local level centered on geographical and political boundaries, conflict around roles, managing credentialing, and event ownership.

Fiscal issues. Fiscal management was cited as a problem in about half the responses. Although funds arrived quickly from the federal level into the state coffer, the challenge became how to access the funds. As one director observed,

> The money doesn't really come to you. It goes first to the state, so then you sort of find out who might be there to talk to you about this. The agencies knew that it was there, that they

> had to access it too and then it had to be transferred to [anonymous]. We finally figured out that there had to be a transfer from [one] Agency to the Department of [anonymous]. . . . Then educating the financial people and the administrators there that this money was coming, and that it could be accessed as of a certain date. It was extremely difficult.

State administrative procedures occasionally resulted in a misrepresentation of the status of the program. A failure to notify programs that extra money had been approved and deposited occasionally resulted in the closing of programs too early and the administrative need to account for money that had not been spent and now had to be given back. Many state systems were not set up for efficient and effective transfer of these funds. These delays were compounded by subsequent delays in paying providers. Directors relied on the relationships they had with providers to begin services, but services were often delayed or stopped when payments did not arrive in a timely manner. One director reported, "They had to trust me that the money would eventually get there. [I] have a relationship with them. They trusted me. They all eventually got funding, but it was slow." Similarly, another said, "Area programs could do nothing until they got funding. They couldn't get funding for weeks and weeks because of the state system."

A separate fiscal issue involved the restrictions for the use of the CCP funds. Concerns were raised about the inability to use the funds for preparedness, administrative costs, food for workers, and program tools such as scrapbooks and event monuments.

Phasing out the response

By and large, the actual length of the CCPs was described as adequate. Typically, the decision to end a CCP was based on funding or diminished need. In most cases, community need was determined by feedback from workers in the field. Very few interviewees stated that the decision to begin phasing down was based on data. When need continued, directors reportedly requested extensions; however, this request complicated programs by keeping the end date "up in the air" while the extension was being considered. One director characterized the close date as a "moving target." Another observation was that the length of the Immediate and Regular Services Grants meant that, in the absence of extensions, phase down officially corresponded with the first anniversary of the disaster. This was thought to be a poor time to end the program as distress often increases and mental health needs reemerge around the anniversary.

Phasing down a program resulted in job loss for most of the CCP staff. Therefore, phase down was often complicated by the fact that many staff left the CCP for new positions before the CCP ended. In several cases, directors thought that staffs' desire to continue the CCP stemmed more from their own needs than from the actual need of the community.

In general, directors felt prepared to handle the phase down of their programs. Most directors did not report any issues with the process of close out. A few, however, stated that they wished they had had further guidance. In a few cases, admin-

istrative positions were created or amended to include a disaster coordinator. The majority of directors reported that little was left behind in terms of either infrastructure or educational products. Even when such products were left behind, there were questions as to whether they would actually be used again.

Evaluating the program

Evaluation attempts of any kind were acknowledged as critical but were conducted by only about half of the CCPs. There were no consistent or systematic attempts to evaluate across programs that we studied. Of those that conducted any evaluation, most involved the collection of anecdotal reports or receipt of feedback via newspapers, field reports, field visits, and responding agencies. A few programs attempted surveys, usually conducted by outreach workers without the benefit of training to conduct the survey. Four programs reported that they had contracted evaluations of their program. Of those, only two reported useful findings. Response rates, when reported, were less than 20 percent. A few program directors mentioned resistance surrounding the idea of evaluation. At times, the resistance was related to program members' reluctance to being evaluated or measured, and at other times, the resistance came from the federal level, where an evaluation component was not approved as part of the grant. But several of the directors, understanding the commitment to "do no harm," also recognized the need to know and understand the effectiveness of their program in their community, saying,

> That is an area that I wish, and I know that they are working on this, CMHS really needs to have evaluation as a mandated component of the program, because there's nothing that talks about why this program should continue, why it has continued all this time, what good is it. You know, I find that . . . really bad. It's bad because it can jeopardize the program.

Conclusions and Recommendations

Previous writings on the provision of mental health services in the aftermath of disaster called attention to a wide range of potential challenges. These writings were primarily first-person accounts or were focused on particular responses, with unknown generalizability to other programs. We aimed to expand upon this accumulated clinical wisdom by studying, for the first time, a representative sample of programs, events, and directors. Our study captured responses to thirty-seven different disasters that varied in type, magnitude, scope, and setting. Despite this diversity, program directors showed substantial agreement about the nature of the challenges that states confront in planning, applying for, implementing, maintaining, phasing out, and evaluating crisis counseling programs. The findings from these interviews yielded several recommendations that may improve the rapidity

and effectiveness of responses aimed to address the psychosocial needs of disaster victims.

First, it is clear that all states require a disaster plan and that mental health should be an integral part of this plan. Ongoing federal support may be needed for states to become and remain prepared. Plans should include dedicated resources that can be mobilized and accessed immediately. Written mental health response plans may help to ensure knowledge transfer from one event to another and from one person to another. Plans should include a designated disaster mental health coordinator with a clear job description, explicit mechanisms to build capacity by developing collaborative relationships with key agencies, and communication venues. Relationships should be formalized through contracts and/or memoranda of understanding. Special emphasis should be placed on developing partnerships with faith-based communities and schools. The best preparedness training plans include table-top and in vitro exercises.

Particularly helpful components of the [FEMA] training included learning from others who had experienced a disaster and assistance with grant writing.

There are four key recommendations regarding federal trainings for state disaster mental health coordinators. First, it would be helpful to establish a curriculum that progresses through the process of disaster mental health response. Second, instead of having a class each year that focuses on grant writing, an initial grant writing course might be followed by an intermediate or advanced course, as appropriate. Third, it would be helpful to develop online courses that augment the Emmitsburg training. Suggested topics include cultural competence, developing collaborative relationships, writing a disaster mental health response plan, and developing state capacity. Fourth, during the event, states should be provided with a list of trainers that is matched to their event and their audience.

One of the most common recommendations from these directors was a plea to review the grant application process and consider ways to streamline it. Preparing these applications in the midst of the crisis was highly stressful. Many advocated for changing the present needs assessment formula and procedures to make them more compatible with available data. Building state capacity for conducting needs assessment would likewise be helpful.

Several actions would facilitate the implementation and ongoing administration of these programs. First, program manuals should be created that define and clarify the components of outreach, counseling, and referral. Concurrently, training materials should be created that facilitate the understanding of such manuals. States need clear guidelines regarding the appropriate training and use of paraprofessionals as outreach workers and crisis counselors. Some states needed assistance to navigate state regulations that may conflict with the use of paraprofessionals in these roles.

One of the areas of most consistent difficulty was fiscal management. States should be required to address fiscal issues as part of their applications and to have appropriate mechanisms in place for distributing federal funds to the CCP and its providers. Likewise, federal program administrators should increase their capacity to provide technical assistance in this area.

The federal government should also reevaluate policies with respect to program length. A one-year time frame for the Regular Services Program would avoid having phase down co-occur with the first anniversary.

Finally, we recommend a standardized approach to CCP evaluation that depends less on the initiative and expertise of specific programs. This would encompass a set of common tools and procedures and a process of using the evaluation to help guide services. Additionally, exit interviews conducted with state directors once the program phases down would facilitate the federal program's ability to capture and transfer lessons learned from past responses.

This set of recommendations undeniably implies that significant improvements are needed at the federal level to improve the functioning of the program at the state level. In closing, however, we should make two important caveats to this observation. First, it should be remembered that the nature of qualitative research is to explore the issues surrounding a particular program or entity. This often highlights the feedback that may be perceived as negative or "needs improvement." Although this is valuable information, it is important that we not lose the positive responses and aspects of a program or entity. To that end, we want to acknowledge that many positive comments were made throughout the interviews. Directors felt their programs provided adequate reach and quality of service to the victims of their disasters.

Second, it should be acknowledged that several changes in process within the federal program are consistent with the aforementioned recommendations. For example, an operations manual is in production that should provide the temporal program guidance that many of these directors requested. In addition, as a direct result of this study (which was part of a larger retrospective evaluation project commissioned by SAMHSA), a standardized evaluation protocol was enacted across twenty state programs aiming to provide services to victims of Hurricane Katrina. This new policy provided states with common tools, manuals, and procedures and, for the first time, allowed for cross-site analysis of program reach and outputs. Improving understanding of the accomplishments and challenges of past programs should boost the capacity of federal, state, and local leaders to promote the psychosocial recovery of disaster victims.

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